

## June 12, 2020: National Advocacy Update

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### **HHS will distribute funds to physicians who participate in Medicaid and CHIP**

The AMA has continued to press the U.S. Department of Health and Human Services (HHS) to swiftly distribute funds to assist those physicians who have not previously received any money from the Provider Relief Fund.

The AMA is pleased the department announced it is moving forward to provide some relief. HHS expects to distribute approximately \$15 billion to eligible physicians and organizations that participate in state Medicaid programs and the Children's Health Insurance Program (CHIP) and have not received a payment from the Provider Relief Fund General Allocation. The payment to each provider will be at least 2 percent of reported gross revenue from patient care; the final amount each provider receives will be determined after the data is submitted, including information about the number of Medicaid patients providers serve. Before applying through the enhanced provider relief portal, applicants should:

- Medicaid Provider Distribution instructions (PDF)
- Download the Medicaid Provider Distribution application form (PDF)

### **Comments support expanded Medicare telehealth services**

The AMA expressed strong support for expanded Medicare coverage and improved payment for physician services provided via telehealth during and following the COVID-19 public health emergency (PHE) in a comment letter sent to the Centers for Medicare & Medicaid Services (CMS) in response to its Interim Final Rule with Comments (IFC). Whereas telehealth services used to only be available in rural areas and patients needed to go to specific sites to receive them, the AMA lauded the lifting of geographic and originating site restrictions so that Medicare patients all over the country could access services via telehealth and do so from their homes.

The AMA also had urged CMS to pay for services provided via telehealth during the PHE at the same rate that physicians are paid for these services when they are provided in-person in their offices and

commended CMS for adopting this policy. As the policy change was retroactive, the AMA was also pleased that CMS later indicated that claims for telehealth services would automatically be reprocessed and paid at the new rates without their having to be resubmitted by practices.

The AMA also stated its great appreciation for CMS's adoption of numerous other policy changes that the AMA had urged that were included in the IFC for the duration of the PHE, including:

- | Additions to the list of services covered when provided via telehealth, such as emergency visits and radiation treatment management
- | Coverage of the Current Procedural Terminology (CPT®) codes for audio-only telephone visits
- | Allowing telehealth services to be provided to new as well as established patients
- | Permitting patients to receive telehealth services in their homes
- | Relaxing previous restrictions on the frequency of certain telehealth services, such as inpatient hospital and nursing facility visits
- | Support for provision of remote patient monitoring services

AMA comments on the IFC also looked ahead and recommended that CMS maintain a number of the policies that are available during the PHE for a period of time after the PHE ends. The novel coronavirus is not the only risk that some patients face when they go to a physician's office. AMA comments encouraged CMS to consider continuing to cover telehealth services for patients in their homes for:

- | Established patients with health conditions or functional limitations that make travel to the physician's office difficult or risky
- | New patients whose principal complaint involves symptoms of an infectious disease
- | New or established patients during infectious disease outbreaks, severe weather, public health emergencies, or other situations where travel is undesirable

In addition, if the face-to-face service delivered using telecommunications is equivalent to a service delivered in-person, then the payment amount should continue to be equivalent. The AMA also underscored that physicians should continue to be able to deliver audio-only services to patients who need a telecommunications-based service in the home but who do not have access to a video connection or cannot successfully use one.

With regard to Medicare Advantage risk adjustment, AMA comments called for CMS to continue allowing diagnoses that are submitted for risk adjustment based on two-way interactive audio-video visits to be utilized in Medicare Advantage risk scores after the PHE. The AMA also recommended that the current policy of including diagnoses obtained from audio-video services be extended to audio-only services when the patient is unable to safely participate in an in-person visit or is incapable, due to lack of connectivity, technology or for other reasons, to participate in an audio and

video visit.

## AMA Board of Trustees pledges action against racism, police brutality

At a virtual Special Meeting of the AMA House of Delegates, the AMA Board of Trustees pledged action to confront systemic racism and police brutality, and released the following statement that was approved at its meeting last week:

- | The AMA recognizes that racism in its systemic, structural, institutional and interpersonal forms is an urgent threat to public health, the advancement of health equity and a barrier to excellence in the delivery of medical care.
- | The AMA opposes all forms of racism.
- | The AMA denounces police brutality and all forms of racially motivated violence.
- | The AMA will actively work to dismantle racist and discriminatory policies and practices across all of health care.

The AMA also released a video of the Board reciting this statement as a symbol of its commitment to address racism.

The Board of Trustee's statement builds on an AMA Viewpoint, "Police Brutality Must Stop," by Immediate Past Chair of the AMA Board of Trustees Jesse M. Ehrenfeld, MD, MPH, and AMA Immediate Past President Patrice A. Harris, MD, MA.

The AMA recognizes that worsening inequities, unequal access to care and the disproportionately small number of Black physicians all have roots in past actions of the AMA. In 2008, the AMA apologized for more than a century of policies that excluded Black physicians. In 2019, the AMA hired its first chief health equity officer to establish the AMA Center for Health Equity to solidify AMA's commitment to embed health equity into the DNA of our organization and our work. Over the past few months, the AMA has issued strong statements denouncing police brutality, racism and xenophobia in the language of public officials. The AMA fully understands that there is tremendous work still to be done to ensure that no one is left out and that everyone has the opportunity, conditions, resources and power to achieve optimal health.

## AMA testifies before House subcommittee on COVID-19 serology tests

Dr. Jesse Ehrenfeld testified before the House Oversight and Government Reform Subcommittee on Economic and Consumer Protection on June 9 as part of a briefing entitled, "COVID-19 Antibody Testing: Uses, Abuses, Limitations, and Federal Response." In addition to offering the key differences between diagnostic and serological COVID-19 tests, Dr. Ehrenfeld highlighted the many limitations associated with antibody tests (PDF) and strongly cautioned against their use for individual decision-making, such as whether to return to work, school and congregate living; ignore social distancing recommendations; or discontinue the use of masks in public settings.

While diagnostic tests confirm if a patient has a current, active SARS-CoV-2 infection, antibody testing is designed to help detect if an individual had a past infection and developed an immune response. Yet, serology tests face key limitations including high incidents of false positives, especially in areas of low disease prevalence, and cross reactivity, or the detection of antibodies for both SARS-CoV-2 and other types of coronaviruses. In addition, while individuals develop some form of immunity response after exposure to most viruses, it is unclear when an immune response develops after a COVID-19 infection, how strong this immune response may be and how long the immune response may last.

In response to these clinical limitations, Dr. Ehrenfeld outlined to the subcommittee the AMA guidelines, stating that serology tests should not be used outside of select settings, including population-level seroprevalence studies, evaluation of convalescent plasma donors and as part of a well-defined testing plan for patients working with their physicians. Dr. Ehrenfeld also stressed the importance of alerting physicians and patients of the inherent limitations of serology tests.

Subcommittee Chairman Raja Krishnamoorthi (D-IL) was critical of the Food and Drug Administration's (FDA) initial relaxed regulatory standards pertaining to COVID-19 serology tests, urged invalid "junk tests" to be expeditiously removed from the market and stressed that the public should not use them for individual life decisions. Krishnamoorthi questioned the utility and accuracy of many serological tests and bemoaned the fact that more than 190 antibody tests have entered the market during a period of poor government oversight. Under FDA policy that went into effect mid-March, manufacturers could distribute COVID-19 serology test kits by self-validating the test, notifying the FDA of the self-validation, and providing a disclaimer with the results that the FDA had not reviewed the test and it should not be the sole basis for the diagnosis. This perceived lack of FDA oversight prompted the Subcommittee on Economic and Consumer Protection to launch its own investigation into antibody tests and to issue a report on April 28 urging policy changes. On May 4, the FDA revised its policy on serology tests requiring all manufacturers of these test kits to apply for

Emergency Use Authorization (EUA) within 10 days. This policy change led to many serology tests being pulled from the market. The Centers for Disease Control and Prevention (CDC) also recently issued revised guidelines in line with AMA's position last month.

## **Liability protections are needed for frontline physicians**

The AMA, alongside 138 medical associations and specialty societies, sent a letter to congressional leadership urging them to include the targeted and limited liability protections for physicians as outlined in H.R. 7059, the "Coronavirus Provider Protection Act." In responding to the many challenges presented by the COVID-19 pandemic, American's physicians had to contend with:

- | Inadequate supplies and safety equipment
- | Rapidly changing guidance and directives from all levels of government
- | Suspension of elective in-person visits and procedures
- | Being assigned to work outside their general practice area
- | Rationing care due to equipment shortages
- | Inadequate testing and treatment delays for conditions not related to COVID-19

In these and other situations, physicians face the threat of costly and emotionally draining medical liability lawsuits due to circumstances that are beyond their control. These lawsuits could come months or even years after the current health emergency has passed. In light of this, the AMA is calling on Congress to pass liability protections that are not universal, but are intended to provide targeted and limited protections where health care services are provided or withheld in situations that may be beyond control of physicians and facilities (e.g., following government guidelines, directives, lack of resources) due to COVID-19. The protections extend to those who provide care in good faith during the COVID-19 response effort and not in situations of gross negligence or willful misconduct.

## **Policies must address COVID-19 impact on minoritized communities**

The need for the nation to move forward on improving health equity is demonstrated by the dramatically disproportionate impact the COVID-19 pandemic has had on racial and ethnic minoritized communities, the AMA told Congress.

"The COVID-19 pandemic has revealed starkly the disproportionate impact of the virus on communities of color," the AMA told the U.S. House Ways and Means Committee. "The causes of the disproportionate impact are rooted in this country's historical and structural racism and the social,

economic, and health inequities that have resulted, and continue to result in, adverse health outcomes."

The AMA submitted a statement for the record to the committee in connection with the panel's recent hearing, "The Disproportionate Impact of COVID-19 on Communities of Color," which—according to committee Chair Rep. Richard Neal (D-MA)—was the first official virtual committee hearing of the U.S. House of Representatives.

"COVID-19 has shone a light on our country's centuries-old legacy of inequality," Neal said, adding that this inequity greatly affects life expectancy in his state—even though Massachusetts leads the nation with the highest rate of residents with health insurance.

In Roxbury, a predominantly Black community, the average life expectancy is 59 years, compared to Back Bay, a predominantly white community, where the average life expectancy is 92 years, Neal said.

The AMA told the panel that the collection and reporting of racial data related to COVID-19 testing, hospitalizations and mortality has been limited. This leads to struggles by physicians and public health authorities to fully attend to the unique needs of their patients and populations, and it hampers the efforts of legislators to design well-informed policies that will preserve lives.

Learn more about why national COVID-19 patient data is vital to fixing inequity.

While data is incomplete, some alarming statistics are coming to light:

- | Black Americans are dying at nearly two times their national population share, and in five out of the six counties with the highest COVID-19 death rates, they are the largest racial group, according to the COVID Racial Data Tracker.
- | The Latinx community accounts for 49% of Virginia's COVID-19 cases where ethnicity is known despite accounting for only 10% of the state's population. Similarly, in Iowa and Wisconsin, the COVID-19 infection rate for Latinx individuals is five times their population share.
- | American Indian/Alaska Natives are also disproportionately affected, and American Indians account for 60% of COVID-19 cases in New Mexico where they are only 9% of the state's population, and 21% of COVID-19 deaths in Arizona where they are just 4% of the population.

The testimony cites three key factors why African Americans are at higher risk for COVID-19:

- | Structural inequities and social determinants of health (SDOH) that are influenced by bias and racial discrimination.

- | Essential non-health care jobs, such as bus drivers, train operators and custodians, are overrepresented by communities of color.
- | Pre-existing conditions, such as diabetes, hypertension and obesity, are disproportionately higher among African Americans, in large part due to generations of food insecurity, lack of access to comprehensive medical care, and lack of access to safe green spaces for exercise and play.

Learn more about why African American communities are being hard hit by COVID-19.

"Additional SDOH considerations have also contributed to the disproportionate impact of COVID-19 on marginalized and minoritized communities, including poverty, lack of access to health care, nutritious food, affordable housing, and accessible transportation, as well as congregate living with multi-generational family members and the fact that many people of color work 'essential' jobs that increase their exposure to the virus, such as in meatpacking plants, warehouses, supermarkets, hospitals, and nursing homes," states the AMA testimony.

More than 28% of people diagnosed with COVID-19 in the U.S. are Hispanic, but the effect of COVID-19 on this community has not been widely addressed, the testimony states, quoting Aletha Maybank, MD, MPH, chief health equity officer and group vice president of the AMA.

Learn details on COVID-19's impact in Latinx communities.

Citing the World Health Organization, the AMA told Congress that avoidable health inequities are produced and do not have to exist. There are actions that can close the gap.

To promote equity and to reduce differences in health outcomes, the AMA recommended Congress adopt the following policies:

**Address implicit bias and unconscious bias.** These biases are learned stereotypes that are automatic, unintentional, deeply engrained, universal and able to influence behavior. Demonstrated impacts of these biases include disproportionate mortality among pregnant Black women. Moreover, shifting only evaluating individual levels of bias to also incorporating structural transformations that apply an equity lens in all medical practices, policies and organizational performance metrics is imperative.

**Address data challenges.** Without improvements in data collection at all levels of government, it is difficult to know where virus "hot-spots" are occurring, and where testing and other resources need to be focused. The AMA worked with members of the House of Representatives to develop H.R. 6585, the "Equitable Data Collection and Disclosure on COVID-19 Act of 2020," which would require HHS to collect and report racial, ethnic, and other demographic data on COVID-19 testing, treatment and fatality rates.

**Address SDOH.** Social risk factors, such as lack of access to health care, nutritious food, affordable housing and accessible transportation, must be addressed beyond just the parameters of the pandemic. The AMA supports H.R. 4004, the "Social Determinants of Health Accelerator Act," which is aimed at providing local communities with the funding and planning tools to implement solutions to the SDOH.

**Invest in professional diversity.** There is a need to expand the pipeline of racially and ethnically diverse, practicing physicians. This need extends to medical school, residency and physicians in teaching and academic settings.

"It will take all of us working in partnership—and the AMA is committed to doing so—to build and continue on a path forward to address not only the specific health disparities that the COVID-19 pandemic has revealed, but also the underlying structural and institutional racism and SDOH and to advance health equity," the AMA testimony states.